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healthstat
inspiring healthy change

Health and Wellness Questionnaire (HaWQ) ™

Please Type or Print all Information Legibly

Please Completely Fill in ○'s
Correct: ● Incorrect: ⊘ ✓ ⊘ ⊗

Last Name: Suffix (Jr, Sr, III):

First Name: MI: Social Security #: - -

Member ID: Employee ID:

Date of Birth (month/day/year): / / Home Telephone #: - - Gender: ○ Male ○ Female

Mailing Address:

City: State: Zip Code:

Language Preference: ○ English ○ Spanish ○ Other (Specify):

Ethnic Background: ○ African-American ○ Asian ○ Caucasian ○ Hispanic
○ Other:

The following questions may need to be completed with a representative assisting patient:
Do you have a vision impairment that requires special reading materials (braille, large print, etc)? ○ No ○ Yes
Do you have a hearing impairment that requires special equipment (hearing aid, TDD, etc)? ○ No ○ Yes

Employee Status: ○ Employee ○ Dependent
If you are the Dependent of an Employee what is your Relationship to Employee? ○ Spouse ○ Child ○ Other
Employee's SSN - -

If a Healthstat Health Coach tried to call you to offer information, what would be the best time to call? ○ Early Morning (Before 8:00am) ○ Daytime ○ Evening Hours (5:00 - 9:00pm)
What Phone # should we call: - -

Medical History

	None	1-2 times	3-5 times	>5 times
In the past year, how many times have you been to a Doctor's office?	○	○	○	○
In the past year, how many times have you been to the Emergency Room?	○	○	○	○
In the past year, how many times have you been admitted to the Hospital?	○	○	○	○

When was your last Physical Exam with a Health Care Provider? ○ 1 year or less ○ More than 1 year ○ More than 2 years ago

Do you have a personal physician? ○ Yes ○ No

Personal Physician's Name :

Physician's City of Practice State

Have you ever been diagnosed by a Health Care Provider as having the following (Please fill in all that apply):

○ Abdominal Aortic Aneurysm	○ Carotid Artery Disease	○ Diabetes	○ HIV/Aids	○ Prostate Cancer
○ Acid Reflux/Heartburn	○ Chest Pain/Angina	○ Emphysema	○ Liver Disease	○ Stroke
○ Arthritis/Joint Pain	○ Chronic Back Pain	○ Heart Attack	○ Neurologic Disease (Parkinson's)	○ Thyroid Disease
○ Asthma	○ Chronic Fatigue	○ Heart Failure	○ Osteoporosis	
○ Blood Disorder (i.e. anemia)	○ Chronic Pain	○ Heart Rhythm Problems	○ Peptic Ulcers	
○ Breast Cancer	○ Colon Disease	○ High Blood Pressure	○ Peripheral Artery Disease	○ Other (Please list):
○ Cancer, other	○ Depression	○ High Cholesterol		

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Do you currently take medication for any of the following conditions (select all that apply)?

O Allergies O Asthma O Diabetes O Depression O High Blood Pressure O High Cholesterol

O Thyroid Disease O Other: [ ]

If you are a diabetic, do you get your Hemoglobin A1c (HgBA1c) checked regularly? O YES O NO O NOT SURE

Do you use any tobacco products (cigarettes, cigars, snuff, tobacco)? O YES O NO

If YES, what is your willingness to quit? O Not ready to quit O Considering quitting O Ready to quit

Do you drink more than five alcoholic beverages per week? O Yes O No

Do you exercise for at least 30 minutes three times per week? O Yes O No

If you are a male, have you had a PSA (prostate) test in the past 12 months? O Yes O No

If you are a female, 40-59 years old, have you had a mammogram in the past 1-2 years? O Yes O No

If you are a female, have you had a Pap Smear test in the past two years? O Yes O No

Are you satisfied with your daily nutrition and eating habits? O Yes O No

If you are over the age of 50, when was the last time you had a colon cancer screen (colonoscopy or sigmoidoscopy)?

O Have never had one/Not Sure O Less than 5 years O Greater than 5 years

Over the past 3 months, how much of an impact do you think your health has affected your ability to be fully productive a work?

O Has had no impact O Has had a little impact O Has had significant impact

How many days of work have you missed in the past year as a result of illness?

O None O <1 week O 1-2 weeks O >2 weeks

How many hours of sleep do you get in an average night? O <4 hrs O 4-6 hrs O 7-8 hrs O >8 hrs

When you drive or ride in a vehicle, how often do you wear a seatbelt? O Never O Sometimes O Always

How would you describe your overall mental stress level? O Low O Medium O High

How would you describe your overall health? O EXCELLENT O VERY GOOD O GOOD O FAIR O POOR

How willing are you to make changes to improve your health?

O I don't feel that I need to make any changes related to my health

O I am not willing to make changes to impact my health

O I know that changes are needed to improve my health but not sure how to begin

O I am aware of my health risks and have a strong desire to improve my overall health

Lab Requisition Sticker

FOR HEALTHSTAT USE ONLY

Plant ID: [ ][ ][ ][ ][ ] Assessment Date: [ ][ ] / [ ][ ] / [ ][ ][ ][ ]

O Blood Draw attempt unsuccessful; No specimen taken. O Copy of blood analysis provided in lieu of blood draw and attached.

Weight (pounds): [ ][ ][ ] Height: [ ] (feet) [ ][ ] (inches) Waist Circumference: [ ][ ] (inches)

Systolic BP (high #) [ ][ ][ ] Diastolic BP (low #) [ ][ ][ ]

O Biometrics completed by physician office

Physician Signature: _____

Body Fat: [ ][ ] . [ ] % If participant takes blood pressure medication, was it taken today? O YES O NO

I have read and signed the Healthstat Notice of Privacy Practices form O YES O NO

By signing this document, I hereby authorize Healthstat, Inc., the on-site practitioner, the clinical reference laboratory processing my blood specimens, and my employer's health plan administrator to disclose my individually identifiable health information, for the purposes of rendering care in the Healthstat clinics. I give Healthstat, Inc. permission to collect the health and wellness information contained above. This information will be used to create my personalized health risk report and will also be confidentially provided to the onsite clinician to advise them of my health status and potential health risks. Any other release of this information must be done so with my written consent.

X _____ _____

Patient or Legal Guardian Signature Date

If the patient's representative signs this form, please provide the following:

_____ _____ _____

Name of Representative Signature of Representative Relationship to Patient